LIMITED SCOPE MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2008

COPIC INSURANCE COMPANY
7351 East Lowry Blvd.
Denver, CO 80230

NAIC #: 11860
NAIC Group Code: N/A

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

COPIC INSURANCE COMPANY
7351 East Lowry Blvd.
Denver, CO 80231

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2008

Prepared by

State Market Conduct Examiners

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State Actuary

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And

Independent Contract Examiner

Kathleen M Bergan, CIE

March 4, 2010

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Morrison:

In accordance with §§ 10-1-203 and 10-3-1106, C.R.S., a limited market conduct examination of the medical malpractice and long-term care business of COPIC Insurance Company has been conducted.

The examination was conducted at the Company's office located at 7351 East Lowry Boulevard, Denver, CO, 80230. The examination was a limited market conduct review of the Company's administrative functions, forms, rating, rate and product filings, claims and underwriting files involving medical malpractice and long-term care business.

The examination covered the period from January 1, 2008 through December 31, 2008.

A report of the examination of COPIC Insurance Company is, herewith, respectfully submitted.

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MARKET CONDUCT
EXAMINATION REPORT
OF
COPIC INSURANCE COMPANY

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COMPANY PROFILE

The following profile is based on information provided by the Company:

COPIC Insurance Company (COPIC) began when physicians from the Colorado Medical Society formed COPIC Trust (a self-insurance trust) on June 30, 1981 under the Hospital and Health Care Trust Act of 1977. The Trust incorporated COPIC Insurance Company as a fully licensed and regulated Colorado domiciled insurance company in September 1984. COPIC began issuing medical malpractice policies on January 1, 1985. Medical malpractice is also referenced – by the company and in its policy forms – as "medical professional liability" or "professional liability" insurance. As of September 30, 2009, COPIC insured 5,991 Colorado physicians against medical malpractice.

COPIC began issuing medical malpractice insurance policies to health care facilities in 1994. COPIC also offers commercial general liability insurance to those facilities that purchase medical malpractice insurance, but no commercial general liability insurance policies are sold to facilities that do not have medical malpractice insurance with COPIC. Both acute care facilities and ambulatory surgical centers are insured as health care facilities. Currently, as of September 30, 2009, COPIC insured eighty-six (86) health care facilities in Colorado, and seventy-eight (78) of those have both medical malpractice and commercial general liability insurance policies. In addition, twenty-nine (29) facilities also carry umbrella policies.

COPIC Insurance Company is organized as a for-profit corporation under Colorado law. The Trust owns 100% of the stock in COPIC Insurance Company and also owns all the other assets of the COPIC Companies, including the commercial building at Lowry. There are no owners of COPIC Trust. Upon dissolution of COPIC Insurance Company, assets remaining after satisfaction of all liabilities would be distributed by the Trustees for the benefit of medicine in Colorado. Due to its ownership structure, COPIC Insurance Company is operated like a not for profit company. Premiums are established using the best available actuarial data, looking forward in time. When loss experience is better than expected, distributions are returned to policyholders as premium credits. Since COPIC started paying distributions in 1990, $123.6 million dollars has been returned to policyholders as distributions.

COPIC is currently licensed to write medical malpractice in Colorado, Nebraska, Iowa, Wyoming, Utah, Arizona, Kansas, Idaho, and Montana. No policies are issued outside of Colorado, Nebraska and Iowa.

COPIC's "A" rating from A.M. Best was reaffirmed in 2008.

*As of December 31, 2008, the Colorado direct premium written for COPIC was $93,922,000 for the medical malpractice line of business, $3,932,000 for the long-term care line of business, and $2,617,000 for the other liability market, for a total of $100,471,000. This represents the following market shares:

- 47.95% share of the medical malpractice market, and
- .31% share of the other liability market, for a total of
- 1.23% share of all property and casualty business written in Colorado in 2008.

This also represents:

- 2.03% of the long-term care market, for a total of
- .30% of the accident and health business written in Colorado in 2008.

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners and actuarial staff with the Colorado Division of Insurance (Division), who were assisted by an independent contract examiner, reviewed certain business practices of COPIC Insurance Company (COPIC or the Company). This procedure is in accordance with Colorado insurance law §10-1-204, C.R.S., which empowers the Commissioner to supplement the Division's resources to conduct market conduct examinations. The limited scope market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of this limited scope examination was to determine the Company's compliance with Colorado insurance laws related to its medical malpractice and long-term care policies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners and the Division. In reviewing material for this report the examiners relied primarily on records and material maintained and/or submitted by the Company. The examination covered a twelve (12) month period of the Company's operations, from January 1, 2008 to December 31, 2008.

File sampling was based on a review of new business, renewal, declination, cancellation and non-renewal files and claim files that were randomly selected from data provided by the Company. Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. Upon review of each file any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each sample, the Company was provided a summary of the findings for that sample. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. References to any practices, procedures, or files which manifested no improprieties were omitted.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases involving monetary values. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, and ten percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance were also included.

The report addresses medical malpractice insurance and long-term care coverage and contains information regarding deviation from Colorado insurance law. The examination included review of the following:

Company Operations and Management
Advertising, Marketing and Sales
Producers
Contract Forms
Rating
New Business Applications and Renewals Processes
Cancellations/Now-Renewals/Declinations and Rescissions Processes
Claims

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance of such practices by the Division. Examination findings may result in administrative action by the Division.

A copy of the Company's official response to this final Market Conduct Report, if applicable, can be obtained upon request from the Division.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

Exhibit 1

Law	Subject
Section 10-1-120, C.R.S.	Reporting of medical malpractice claims.
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected fraud – qualification.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-4-107, C.R.S.	Cancellation of medical malpractice policies.
Section 10-4-108, C.R.S.	Notice.
Section 10-4-109, C.R.S.	Nonrenewal of medical malpractice policies.
Section 10-4-109.5, C.R.S.	Notice of intent prior to unilateral increase in premium or decrease in coverage previously provided in medical malpractice policies.
Section 10-4-401, C.R.S.	Purpose – applicability.
Section 10-4-402, C.R.S.	Definitions.
Section 10-4-403, C.R.S.	Standards for rates – competition – procedure – requirement for independent actuarial opinions regarding 1991 legislation.
Section 10-4-404, C.R.S.	Rate administration.
Section 10-4-404.5, C.R.S.	Rating Plans – property and casualty type II insurers – rules.
Section 10-4-407, C.R.S.	Hearings
Section 10-4-413, C.R.S.	Records required to be maintained.
Section 10-4-415, C.R.S.	Prohibition of anticompetitive behavior.
Section 10-4-416, C.R.S.	Prohibited changes in rates or coverages.
Section 10-4-417, C.R.S.	False or misleading information.
Section 10-4-419, C.R.S.	Claims-made policy forms.
Section 10-4-420, C.R.S.	Risk Management Procedures.
Section 10-4-421, C.R.S.	Notice of rate increases and decreases.
Section 10-16-106, C.R.S.	Group replacement – extension of benefits.
Section 10-16-107, C.R.S.	Rate Regulation – rules – approval of policy forms – benefits certificates – evidences of coverage – benefits ration – disclosures on treatment of intractable pain.
Section 10-16-107.1, C.R.S.	False or misleading information – penalties.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.5 C.R.S.	Fair marketing standards.
Section 10-16-118, C.R.S.	Limitations on pre-existing conditions.
Section 10-16-110, C.R.S.	Fees paid by health coverage entities.
Section 10-19-103, C.R.S.	Definitions.
Section 10-19-104, C.R.S.	Scope and applicability of article.
Section 10-19-105, C.R.S.	Extraterritorial jurisdiction – group long-term care insurance.
Section 10-19-106, C.R.S.	Rules on disclosure.
Section 10-19-107, C.R.S.	Performance standards.
Section 10-19-108, C.R.S.	Requirements for preexisting conditions.
Section 10-19-109, C.R.S.	Requirements for prior hospitalization or institutionalization.

Section 10-19-110, C.R.S.	Loss ratio standards.
Section 10-19-111, C.R.S.	Right to return policy – free look.
Section 10-19-112, C.R.S.	Outline of coverage – certificate.
Section 10-19-113, C.R.S.	Option for inflation adjustment – renewability.
Section 10-19-113.3, C.R.S.	Incontestability period.
Section 10-19-113.4, C.R.S.	Nonforfeiture of benefits – rules.
Section 10-19-113.6, C.R.S.	Producer training requirements.
Section 10-19-113.7, C.R.S.	Rules.
Section 10-19-114, C.R.S.	Compliance.
Section 10-19-114.5, C.R.S.	Penalties.
Section 13-64-201, C.R.S.	Legislative declaration.
Section 13-64-303, C.R.S.	Judgments and settlements – reported.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile With Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-11	Rate Filing Submissions For Health Insurance
Insurance Regulation 4-4-1	Concerning Requirements for Long-Term Care Insurance
Insurance Regulation 5-1-8	Concerning Claims-Made Insurance Policies
Insurance Regulation 5-1-10	Concerning Rate and Rule Filing Submission Property and Casualty Insurance
Insurance Regulation 5-1-11	Risk Modification Plans

Prior Examinations

The Company has not been the subject of a previous market conduct examination. The Company was the subject of a previous financial examination which was completed August 29, 2008, for the period of January 1, 2003 to December 31, 2007.

Company Operations and Management

The examiners reviewed Company management, quality controls, record retention, antifraud plan, forms certification, and timely cooperation with the examination process.

Advertising, Marketing and Sales

The examiners reviewed the Company's advertising, marketing and sales materials.

Contract Forms and Endorsements

The examiners reviewed the following contract forms, endorsements, and disclosure forms in use during the exam period for compliance with the appropriate statutes and regulations:

Form Title	**Form Number**
Medical Professional Liability Policy	COPIC Insurance Policy Form CO PLI (01/08)
Miscellaneous Medical Professional Liability Policy	COPIC Insurance Policy Form CO MML (01/08)
Health Care Facility Liability Policy	COPIC Insurance Policy Form CO HPL 03/08
Health Care Facility Umbrella Policy	CO UMB Policy (03/05) (Revised 10/04)
COPIC CARE Long-Term Care Insurance	COPIC-LTC-03/08
COPIC CARE Long-Term Care Insurance Coverage	LTC-G-COPIC 8/2006
COPIC CARE Long-Term Care Insurance	LTC-CD9-COPIC (No date)
COPIC CARE *Premier* Long-Term Care Insurance	LTQ11-336-CP-998
Copic Care Long-Term Insurance Policy – Group	LTC-GMP-COPIC
Blank Schedule of Benefits Form	No Form Number
Declarations Page (CO PLI & CO MML)	CIC-SP018D 09/2005
Part Time Retired Endorsement	CIC-1005G 10/10/2001
Excluded Procedure Endorsement	CIC-1007B 09/2005
Manuscript Free Form Endorsement	CIC-C1023SP 09/2005
Reinstate Policy Endorsement	CIC-C1025B 09/2003
Null/Void Endorsement	CIC-C1032B 09/2003
Additional Insured Endorsement	CIC-C1043B 09/2003
Slot Locations Endorsement	CIC-C1058B 09/2007
Suspend Coverage Endorsement	CIC-C1063B 09/2003
Reinstate Suspended Coverage Endorsement	CIC-C1064B 09/2003
Insured Elsewhere Endorsement	CIC-C1068B 09/2003
Shared Deductible Endorsement	CIC-C1074B 09/2003
Prior Acts Endorsement	CIC-C1079B 09/2005
Individual Deductible Program Endorsement	CIC-C1082G 01/2005
Part Time – NO	CIC-C1087 09/2005
Decrease Limits Endorsement	CIC-C2003N 09/2005
Add Physician Endorsement	CIC-C2004A
Increased Limits Endorsement	CIC-C20007A 09/2005
Change Hours Endorsement	CIC-C2010A 09/2003
State of CO -Contract Endorsement	CIC-C2045A 09/2003
Add Society Endorsement	CIC-C2015A 09/2003
Delete Society Endorsement	CIC-C2016A 09/2003
Add RMHP Endorsement	CIC-C2021A 09/2005
Delete RMHP Endorsement	CIC-C2022A 09/2003
Add ERS Preferred Endorsement Informational.	CIC-C2023A 09/2003
Add ERS Standard Endorsement	CIC-C2023B 09/2003
Add ERS Surcharge Endorsement	CIC-C2023C 09/2003
Delete ERS Preferred Endorsement	CIC-C2023D 09/2003
Delete ERS Standard Endorsement	CIC-C2023E 09/2003
Delete ERS Surcharge Endorsement	CIC-C2023F 09/2003
Add AGRM Discount	CIC-C2026A 09/2003
Delete AGRM Discount	CIC-C2027A 09/2003
Add Administrative. Discount Endorsement	CIC-C2028A 09/2003

Delete Administrative Discount Endorsement	CIC-C2029A 09/2003
Change Named Insured or Mailing Add. Endorsement	CIC-C2030A 09/2003
Add New Physician Discount Endorsement	CIC-C2031A 09/2003
Add Individual Deductible Discount Endorsement	CIC-C2071A 09/2003
Delete Individual Deductible Discount Endorsement	CIC-C2072 09/2003
Change Individual Deductible Discount	CIC-C2073 09/2003
Add Schedule Credit Endorsement	CIC-C2074 09/2003
Delete Schedule Credit Endorsement	CIC-C2075 09/2003
Delete Schedule Debit Endorsement	CIC-C2076 09/2003
Add Schedule Debit Endorsement	CIC-C2077 09/2003
Add Solo Small Group. Discount Endorsement	CIC-C2078 09/2003
Delete Solo Small Group Discount Endorsement	CIC-C2079 09/2003
Change Specialty Endorsement	CIC-C2082 09/2003
Delete Part Time Endorsement	CIC-C2086A 10/01/2001
Policy Cancellation Endorsement	CIC-C2267A 09/2003
Add Slot Physician Endorsement	CIC-C2268A 09/2003
Add Allied Health Endorsement	CIC-C2269A 09/2003
Delete Physician Endorsement	CIC-C2270A 09/2003
Delete Additional Named Insured Endorsement	CIC-C2270AA 09/2003
Delete Allied Health Professional Endorsement	CIC-C2270AH 09/2003
Delete Resident Endorsement	CIC-C2270R 09/2003
Extended Reporting Endorsement	CIC-C2272A 09/2005
Amendatory Endorsement - PC Partnership/Entity ERP Endorsement	CIC-C2273A 10/01/2001
Additional Named Insured Endorsement- Front Range Risk	CIC-C2274A 09/2003
Reinstate Cancellation Risk	CIC-C2275B 09/2003
Contingency Excess Endorsement	CIC-C2276A 09/2003
Change - Kansas only	CIC-C2281 10/2004
Change - Nebraska only	CIC-C2282A 10/2008
Special Conditions Endorsement Letter	No form number, page 66
Restricted Practice by Order - re substance only Endorsement	CIC- 01/2005
Restricted Practice by Order - re forfeit free Tail Coverage Rights Endorsement	CIC-C2283B 11/2007
Governmentally Immune Endorsement	CIC-C2284A 09/2003
Liability Cover for Specific Non-Employed Nurse Midwives Endorsement	CIC-2285 01/2006
Residency Program Endorsement (Moonlighting Exclusion)	CIC-C2286A 09/2006
House Calls Endorsement	CIC-C2289A 09/2008
Territory Change Prior Acts - CO Endorsement	CIC-C2290 01/2006
Employed Vicarious Liability Endorsement	CIC-C2301A 01/2008
Day Spa Vicarious Liability Endorsement	CIC-C2302A 01/2008
Non-Employed Vicarious Liability Endorsement	CIC-C2302A 01/2008
Part Time Insured Elsewhere Endorsement	CIC-C3025 09/2005
Pre-Paid Tail Endorsement	CIC-C8830A 09/2005

Administrative Medicine Endorsement	CIC-9506 09/2003
Change Territory & Limits Endorsement	CIC-C0204A 09/2003
Dec Page	COPIC-DEC-03/08
Forms Index	COPIC-FI-03/08
Amendment to Conditions	COPIC-AC-03/08
Blanket Contractual Liability Coverage	COPIC-BCLC-03/08
Cancellation & Non-Renewal – Colorado	COPIC-CNR-03/08
Excluded Procedures	COPIC-EXPRO-03/08
Government Access to Records	COPIC-GAR-03/08
Limited Pollution or Contamination Liability Coverage	COPIC-LPCC-03/08
Medical Expense Coverage	COPIC-MEC-03/08
Patient Property Damage	COPIC-PP-03/08
Amendatory Endorsement Terrorism	COPIC-BE-03/08
Additional Named Insured Endorsement	COPIC-AI-03/08
Additional Insured - Lessor of Leased Equipment	COPIC-AI-LESSOR-03/08
Additional Insured Endorsement	COPIC-AI/EN-03/08
Additional Insured Gen Liability Only Endorsement	COPIC-AI/EN/GL-03/08
Additional Insured Scheduled Organization Endorsement	COPIC-AI-ORG-03/08
Employee Benefits Liability Schedule	COPIC-EBL-03/08
Air, Food, and Water Coverage Endorsement	COPIC-AFW-03/08
Amendatory Endorsement Blank & Explanation of Use	COPIC-BE-03/08
Amendatory Endorsement Additional Days	COPIC-BE-03/08
Amendatory End, - Volunteer EMTs	COPIC-BE-03/08
CO Gov. Immunity Endorsement	COPIC-CGI 03/08
LTC Endorsement	COPIC-LTC
Coverage A Deductible - Indemnity & Defense Cost Endorsement	COPIC-DED IND and EXP 03/08
Coverage A Deductible - Indemnity End	COPIC-DED IND 03/08
Coverage B Deductible - Indemnity & Defense Cost Endorsement	COPIC-DED IND and EXP 03/08
Coverage B Deductible - Indemnity & Defense Cost Endorsement	COPIC-DED IND 03/08
Coverage C Deductible - Indemnity & Def Costs Endorsement	COPIC-DED COV C IND and EXP 03/08
Coverage C Deductible - Indemnity Endorsement	COPIC-DED COV C IND 03/08
Delete Location(s) Endorsement	COPIC-DL- 03/08
Delete Named Physician Endorsement	COPIC-DNP&S-08/02
Employed Legal Counsel Exclusion	COPIC-ELC-08/02
Extended Reporting Period Endorsement	COPIC-ERP- Policy-03/08
Extended Reporting Period Endorsement. - Individual	COPIC-ERP- Ind.-03/08
Hired and Non-Owned Auto Liability	COPIC-AU-03/08
Special Conditions Endorsement	COPIC-IPIL-03/08
Special Conditions Endorsement	COPIC-IPSL-03/08
Inflight Treatment Endorsement	COPIC-FLT-03/08
Insured Elsewhere Endorsement	COPIC-PTC-03/08

Legal Defense Coverage	COPIC-LD-03/08
Locum Tenens Physician Endorsement	COPIC-LT-03/08
Exclusion -Medical Payments to Children Day Care Centers Endorsement	COPIC-MedPay Exc-03/08
Part-Time Coverage Endorsement	COPIC-PTC-03/08
Physicians and Surgeons -Shared Limit of Liability Endorsement	COPIC-PSE/A-03/08
Physicians and Surgeons - Individual Limit of Liability Endorsement	COPIC-PSE/B-03/08
Prior Acts Endorsement	COPIC-PAC-03/08
Products-Completed Operations Coverage Endorsement	COPIC-PCOC-03/08
Manuscript Endorsement	COPIC-RR-03/08
Schedule of Premises (Owned, Leased, Occupied, Loaned)	COPIC-SP-03/08
Suspension of Coverage Endorsement	COPIC-Suspension-03/08
Reinstate Suspended Coverage Endorsement	COPIC-Reinstate Dr 03/08
Waiver of Transfer of Rights of Recovery Against Others TO Us Endorsement	COPIC-Waiver- 03/08
Colorado Health Care Facility Umbrellas Policy	CO UMB Effective 03/05 (Revised 10/04)
Forms Index	COPIC-FI 10/02
Physician Exclusion - Umbrella Coverage Endorsement	COPIC-UPE-10/02
Amendatory Endorsement - Terrorism	COPIC-BE-10/02
Schedule of Underlying Coverage	COPIC-UC-10/02
Additional and Additional Named Insured Endorsement	COPIC-AI-Named-10/07
Extended Reporting Period Endorsement- Umbrella	COPIC-ERP-UMB-10/02
Products - Completed Operations Exclusion - Umbrella Coverage Endorsement	COPIC-PCOE 10/02
COPIC CARE Long-Term Care Insurance	LTC-G4-COPIC Employees Revised August 20, 1998
COPIC CARE Long-Term Care Insurance Certificates	LTC-G-COPIC – Professional Liability Insureds Revised July 27, 1998
COPIC CARE Group Long-Term Care Insurance Certificate	LTC-G-COPIC (Employees & COC)

Rating:

The examiners reviewed the premium rates charged in the samples of the files selected in the new business and renewal application sections of the examination. There rates were reviewed for compliance with rate filings submitted to the Division as the rates being used during the examination period as well as compliance with the appropriate statutes and regulations.

The examiners also reviewed the company's rate filing and form certification history, and reviewed associated company practices for compliance with Colorado laws and regulations.

New Business Applications and Renewals:

For the period under examination, the examiners randomly selected the following samples for review to determine compliance with underwriting practices and manual rules:

MEDICAL MALPRACTICE POLICY APPLICATIONS

Review Lists	Population	Sample Size	Percentage to Population
New Business Applications	415	86	21%
"Expired" Applications	4	4	100%
"No Further Information" Applications	8	8	100%
Withdrawn Applications	28	28	100%

MEDICAL MALPRACTICE RENEWALS

Review Lists	Population	Sample Size	Percentage to Population
Renewals	6264	116	2%

LONG-TERM CARE COVERAGE POLICY APPLICATIONS

Review Lists	Population	Sample Size	Percentage to Population
New Business Applications	431	86	20%

Long-term Care Renewals (Group and Individual) were not reviewed as they are automatically renewed with the renewal of medical malpractice policies.

Cancellations/Non-Renewals/Declinations and Rescissions:

For the period under examination, the examiners systematically selected the following samples for review to determine compliance with underwriting practices and manual rules:

MEDICAL MALPRACTICE POLICY CANCELLATIONS

Review Lists	Population	Sample Size	Percentage to Population
Cancellations	452	86	19%

MEDICAL MALPRACTICE POLICY NON-RENEWALS

Review Lists	Population	Sample Size	Percentage to Population
Non-Renewals	3	3	100%

MEDICAL MALPRACTICE POLICY DECLINATIONS

Review Lists	Population	Sample Size	Percentage to Population
Declinations	3	3	100%

LONG-TERM CARE COVERAGE POLICY CANCELLATIONS

Review Lists	Population	Sample Size	Percentage to Population
Cancellations	192	79	41%

The Company stated that it had no rescissions for either the Medical Professional or the long-term care lines of business for the examination period. Additionally, as coverage under the long-term care group policy is contingent upon issuance and/or continuance of the medical malpractice coverage, there were no long-term care declinations or non-renewals to review.

Claims:

For the period under examination, the examiners randomly selected the following samples of claims for review to determine compliance with the Company's claims handling practices:

MEDICAL MALPRACTICE CLAIMS

Review Lists	Population	Sample Size	Percentage to Population
Paid Claims	1147	107	9%
Not Paid Claims	336	82	24%
"Umbrella" Claims	1	1	100%
Paid Hospital General Liability Claims	2	2	100%
Not Paid Hospital General Liability Claims	5	5	100%

LONG-TERM CARE COVERAGE CLAIMS

Review Lists	Population	Sample Size	Percentage to Population
Paid	36	36	100%
Denied	2	2	100%

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-three (23) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified three (3) areas of concern in their review of the Company's operations and management.

Issue A1: Failure of the Company's application form to provide information regarding contributions to the Company's Political Action Committee that is not misleading to applicants.

Issue A2: Failure to use, develop and utilize long-term care coverage applications with consequent failure to make determinations and provide notices, forms and disclosures as required by Colorado insurance law.

Issue A3: Failure to comply with Colorado insurance laws with regard to implementation of its long-term care coverage included in medical professional liability policies and provided as a benefit to Company employees.

Advertising, Marketing and Sales: The examiners identified two (2) areas of concern in their review of Advertising, Marketing and Sales.

Issue B1: Failure to develop and implement standards for marketing as required by Colorado insurance law.

Issue B2: Failure to provide to prospective enrollees of long-term care the Shopper's Guide required by Colorado insurance law.

Producers: In the area of Producers, no compliance issues are addressed in this report.

New Business Applications and Renewals: In the area of new business applications/renewals, no compliance issues are addressed in this report.

Contract Forms: The examiners identified fifteen (15) areas of concern in their review of the Company's contract forms.

Issue E1: Failure to include a complete list of forms in its annual reports for claims-made liability insurance coverage certifications.

Issue E2: Failure, in some cases, to include a complete list of forms and some elements of certification in its long-term care health coverage certifications.

Issue E3: Failure, in some cases, to assign a unique identifying form number to claims-made liability insurance policy forms.

Issue E4: **Failure, in some cases, to include the required provisions for cancellation and non-renewal in medical malpractice policy forms.**

Issue E5: **Failure to include in policy forms a provision indicating the insured's approval and acknowledgement, by signature is required on the written endorsement for certain exclusionary changes to the policy at renewal.**

Issue E6: **Failure to clearly and adequately disclose the policy provisions by including incorrect and/or incomplete definitions or statements.**

Issue E7: **Failure to include a statement in long-term care certificates of insurance that the group master policy determines contractual provisions, as required by Colorado insurance law.**

Issue E8: **Failure, in some cases, to provide a disclosure statement form with the required content and format and to execute and maintain the required proof of delivery and acceptance of the disclosure form.**

Issue E9: **Failure to include in long-term care coverage policy form and certificates a provision stating a policyholder must request in writing or sign any amendment which reduces or eliminates coverage.**

Issue E10: **Failure, in some cases, to include definitions which satisfy the requirements of Colorado insurance law.**

Issue E11: **Failure to include a correct provision for continuation of coverage in a long-term care certificate when the eligibility for coverage is based upon a relationship that terminates.**

Issue E12: **Failure, in some cases, to include all elements of an incontestability provision in a long-term care policy or certificate when including the provision.**

Issue E13: **Failure, in some cases, to include the required (thirty) 30-day free look provision, or including it other than on the first page as required under Colorado insurance law.**

Issue E14: **Failure to provide the required Outline of Coverage in the format and with content required by Colorado insurance law.**

Issue E15: **Failure, in some cases, to include the required reinstatement provisions in long-term care group policy coverage and certificates of insurance, and to provide and retain the required forms for notice and waiver of the right to designate another person to receive notice of lapse or termination of long-term care certificate of insurance.**

Rating: The examiners identified two (2) areas of concern in their review of rating.

Issue F1: **Failure to clearly disclose requirements for premium discount and continuing eligibility and provide ninety (90) day notification upon loss of discount.**

Issue F2: Failure, in some cases, to include specific rates, discounts, surcharges, and loads in rate filings as required by Colorado insurance law, or to include actuarial or statistical justification for such rates, discounts, surcharges and loads.

Cancellations/Declinations/Non-Renewals/Rescissions: In the area of cancellations/declinations/non-renewals/rescissions, no compliance issues are addressed in this report.

Claims: The examiners identified one (1) area of concern in their review of the Company's handling of claims.

Issue J1: Failure, in some cases, to report medical malpractice settlements or judgments to the Colorado Board of Medical Examiners within fourteen (14) days from the settlement date as required by Colorado insurance laws.

COPIC INSURANCE COMPANY

FACTUAL FINDINGS

COMPANY OPERATIONS

AND MANAGEMENT

Issue A1: Failure of the Company's application form to provide information regarding contributions to the Company's Political Action Committee that is not misleading to applicants.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (a) Misrepresentations and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, statement, sales presentation, omission, or comparison which:
>
> . . .
>
> (II) Misrepresents the dividends or share of surplus to be received on any insurance policy; or
>
> . . .
>
> (b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a news letter, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading:

It appears that the Company is not in compliance with Colorado insurance law in that its application process requires applicants to actively opt-out of participating in the Company's Political Action Committee (PAC) or "other accounts" funded by "policyholder distribution monies" if they do not wish to contribute.

The Company's application form states the following in part:

> During the policy year for which you are making application, COPIC will allocate no more than $19 of your policyholder distribution monies, if any policyholder distribution is declared by COPIC's Board of Directors and if your application for coverage is accepted by the Company, to its Political Action Committee (PAC) or other accounts for the purpose of supporting Tort Reform in the State of Colorado. If you object to this, please check this box…….☐
>
> Please Note:

> Your consent to our making contributions to our PAC in your name will remain in effect until and unless you change your election at the time you complete a Renewal Application. Depending upon future elective policy changes you may make, it may be more than twelve months before we require that you complete a Renewal Application.
>
> **Non-United States citizens are legally barred from contributing to a PAC. If you are not a United States citizen, you must check the box above.** [Emphasis in original.]

This practice may be inappropriate as it has the potential to create an expectation on the part of the applicant that they could be declined for coverage and/or suffer other adverse outcomes if they choose to opt-out of participation in a future possible donation to support political activities.

The disclosure that "policy distribution monies" may be applied to undefined "other accounts" appears to be ambiguous and /or a misrepresentative and undefined indication of how future distributions will be used.

Finally, the automatic deduction of monies without an indication from the applicant that they are interested in contributing future distributions appears to be a misleading practice in that it occurs automatically, unless the applicant proactively opts out of contributing on a future renewal application.

Recommendation #1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its applications and other relevant forms, along with its practices and procedures pertaining to participation in the Company's PAC to avoid any potential to be misleading to applicants, as required by Colorado insurance law.

Issue A2: Failure to use, develop and utilize long-term care coverage applications with consequent failure to make determinations and provide notices, forms and disclosures as required by Colorado insurance law.

Section 10-19-103, C.R.S., Definitions, states in part:

> (4) *"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to one of the following:*
>
> (a) *One or more employers* or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, *for employees or former employees or a combination thereof or for members or former members or a combination thereof,* of the labor organizations;
>
> . . .
>
> (d) *A group other than as described in paragraph (a), (b), or (c) of this subsection (4), subject to a finding by the commissioner that*:
>
> (I) *The issuance of the group policy is not contrary to the best interest of the public;*
>
> (II) *The issuance of the group policy would result in economies of acquisition or administration; and*
>
> (III) *The benefits are reasonable in relation to the premiums charged.* [Emphases added.]
>
> (5) "*Long-term care insurance" means any insurance policy or rid*er advertised, marketed, *offered, or designed to provide coverage for not less than twelve consecutive months for each covered person* on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. … *The term shall also include qualified long-term care insurance contracts. … Notwithstanding any other provisions contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this article.* [Emphases added.]

Section 10-19-104, C.R.S., Scope and applicability of article, states in part:

> *The requirements of this article shall apply to policies delivered or issued for delivery in this state on or after July 1, 1990.* This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws . . . .[Emphasis added.]

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states, in part:

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

1. Except as provided in Paragraph 2, *this section applies to any long-term care* policy or *certificate issued in this state on or after July 1, 2007.* [Emphasis added.]

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy … which was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2008.

Section 13. Requirements for Application Forms and Replacement Coverage

A. *Application forms shall include the following questions* designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. *With regard to a replacement policy issued to a group defined by §10-19-103 (4)(a), C.R.S., the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.*

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

   a. If so, with which company?

   b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. *Agents shall list any other health insurance policies they have sold to the applicant.*

1. List policies sold that are still in force.

2. List policies sold in the past five (5) years that are no longer in force.

. . .

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner set forth in Appendix I.

E. *Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.* [Emphases added.]

. . . Section 22**.** Suitability

B. *Every insurer,* health care service plan or other entity *marketing long-term care insurance* (the "issuer") *shall*:

1. *Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;*

2. *Train its agents in the use of its suitability standards; and*

3. *Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.*

C.

1. *To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:*

a. *The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;*

b. *The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and*

c. *The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.*

2. *The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph 1 above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet."* The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type (type size is not applicable to internet based worksheets). The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. *The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.*

E. *Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.*

F. *At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.*

G. *If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.*

H. *The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.*[Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that it does not have a long-term care coverage application process that includes an application or enrollment form for its

employees. It has no separate long-term care coverage application form for its medical malpractice coverage applicants.

The medical malpractice coverage application, which also enrolls the applicants in the Company's long-term care coverage does not include the required questions or notices. It appears the Company has no process for determining whether ay of the forms or notices in the appendices of Colorado Insurance Regulation 4-4-1would apply to any applicant. It does not use or provide to its applicants any forms or notices that may be required under Regulation 4-4-1.

Specifically, it appears the Company does not provide the disclosures regarding its rating practices as required in Section 9, the application forms and replacement coverage notice as required in Section 11 and does not have a process for determining suitability as required in Section 22.

While the Company has asserted there has never been a rate increase in the history of its long-term care coverage program, the policy and three (3) of four (4) certificates clearly indicate the possibility of a rate increase. The possibility of a rate increase triggers the requirement for disclosure of rating practices to consumers.

The group master policy includes the following statements:

> The initial premium is listed in the Insured Person's Certificate Schedule. The Company may change the premium amount by providing 31 days advance written notice.
>
> No change will be made to the premium amount unless the premium rates change for all persons in the same payment class

Form Number	Name	Edition Date
LTC-GMP-COPIC	Copic Care Long-Term Care Insurance	None Provided
LTC-G2_Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-19-103 and 10-19-104, C.R.S. and Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has developed appropriate forms, submitted updated form certification filings, and has implemented necessary procedural changes for its long-term care insurance in order to ensure compliance with Colorado insurance law.

Issue A3: Failure to comply with Colorado insurance laws with regard to implementation of its long-term care coverage included in medical professional liability policies and provided as a benefit to Company employees.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices states in part:

> *(1) The following are defined* as unfair methods of competition and *unfair or deceptive acts or practices in the business of insurance:*
>
> . . .
>
> (s) *Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates.* Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

Section 10-19-103, C.R.S., Definitions, states in part:

> (1) "Applicant" means:
>
> …
>
> (b) In the case of a group long-term care insurance policy, the proposed certificate holder.
>
> . . .
>
> (2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.
>
> . . .
>
> (4) *"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to one of the following:*
>
> (a) *One or more employers* or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, *for employees or former employees or a combination thereof or for members or former members or a combination thereof,* of the labor organizations;
>
> . . .
>
> (d) *A group other than as described in paragraph (a), (b), or (c) of this subsection (4), subject to a finding by the commissioner that*:
>
> (I) *The issuance of the group policy is not contrary to the best interest of the public;*

(II) *The issuance of the group policy would result in economies of acquisition or administration; and*

(III) *The benefits are reasonable in relation to the premiums charged.* [Emphases added.]

Section 10-19-104, C.R.S., Scope and applicability of article, states:

> *The requirements of this article shall apply to policies delivered or issued for delivery in this state on or after July 1, 1990.* This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article; except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. [Emphasis added.]

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states, in part:

> Section 26. Discretionary Powers of the Commissioner
>
> *The commissioner may* upon written request and *after an administrative hearing,* issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:
>
> A. The modification or suspension would be in the best interest of the insureds;
>
> B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
>
> C.
>
> 1. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
>
> 2. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
>
> 3. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

It appears that the Company is not in compliance with Colorado insurance law in that it has conducted its long-term care coverage program as if it was and is exempt from complying with Colorado long-term care insurance laws in the absence of a formal written exemption from the Commissioner or documentation of the required administrative hearing for an exemption having taken place.

The Company has also certified with the Division of Insurance that its long-term care forms were in compliance with Colorado insurance laws. However, as evidenced by Issues E7, and E9 – E15, some of the forms were not in full compliance with Colorado insurance laws.

The Company explained that it had assurances of an exemption from the Division of Insurance prior to implementing the program in 1997, and provided affidavits from Company officials to this effect. However, the Company has provided no documentation from the Division of Insurance to support its position that the Division of Insurance approved any exemption to compliance with any Colorado insurance laws or regulations. The Division does not have any record of such exemption in its files.

Colorado Insurance Regulation 4-4-1 was amended effective 1/1/2008 to include, among other amendments, the addition of Section 26, which makes it applicable to the examination time period. In addition, §§ 10-19-103, and 10-19-104, C.R.S.. were repealed and reenacted in 1990. These laws were in effect in 1997.

There is a formal process for a "finding by the commissioner". When there is a finding by the commissioner, there is a written record documenting that finding. The Company has asserted its understanding from alleged 1997 discussions and has provided affidavits stating the Company's understanding of the events leading up to the implementation of its long-term care program. The Company has provided no written evidence of an exemption, modification or suspension of any provision of Colorado insurance law for its long-term care coverage program, and no documentation of any assurances of compliance from the Division of Insurance.

Recommendation #3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-19-103, 10-19-104, C.R.S. and Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its long-term care forms, filed certifications and distributed the revised forms to insured persons, and that it has either completed those processes required, or revised its long-term care program in order to ensure compliance with Colorado insurance law.

ADVERTISING, MARKETING AND SALES

Issue B1: Failure to develop and implement standards for marketing as required by Colorado insurance law.

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 21. Standards for Marketing
>
> A. *Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall*:
>
> 1. *Establish marketing procedures and agent training requirements to assure that:*
>
> a. *Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and*
>
> b. *Excessive insurance is not sold or issued.*
>
> . . .
>
> 3. *Provide copies of the disclosure forms required in Section 9(C), (Appendices B and F), to the applican*t.
>
> . . .
>
> 5. *Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.*
>
> 6. *If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.*[Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that it has no standards for marketing and no procedures for auditing marketing standards, does not provide copies of specifically required disclosure forms and does not provide written notice to prospective certificate holders of the name address and telephone number of the senior counseling program as required by Colorado insurance law.

Recommendation #4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has developed and implemented the marketing standards required in order to ensure compliance with Colorado insurance law.

Issue B2: Failure to provide to prospective enrollees of long-term care the Shopper's Guide required by Colorado insurance law.

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 24. Requirements to Deliver Shopper's Guide
>
> A. *A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate*. [Emphasis added.]
>
> 1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.
>
> 2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

It appears that the Company is not in compliance with Colorado insurance law in that no shopper's guide is delivered to prospective enrollees.

Recommendation #5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure to include a complete list of forms in its annual reports for claims-made liability insurance coverage certifications.

Section 10-4-419, C.R.S., Claims-made policy forms, states in part:

> (1) *No insurer shall use or issue any policy, certificate, or contract of insurance or any portion thereof which provides coverage on a claims-made basis unless it has been certified by the insurer and the insurer has filed a certification with the commissioner* that such policy endorsement or disclosure form or any portion thereof which provides coverage on a claims-made basis conforms to Colorado law pursuant to subsection (2) of this section and any rules and regulations promulgated pursuant to subsection (3) of this section.
>
> . . .
>
> (7) *All insurers providing insurance on a claims-made basis* and who are authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, disclosure form, or any other evidence of coverage issued* or delivered to any policyholder in Colorado. Such listing shall be submitted by July 15, 1993, and not later than July 1 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or disclosure form in use complies with Colorado law. *The necessary elements of the certification shall be determined by the commissioner.* [Emphases added.]

Colorado Insurance Regulation 1-1-6, promulgated under the authority of §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states in part:

Section 3. Applicability and Scope

> *This regulation applies to all insurers and other entities authorized to conduct business in Colorado which provide … claims-made liability insurance … who are required to fully execute and file, with each Listing of New Policy Forms or Annual Report of policy forms, a certification. …* [Emphasis added.]

Section 4. Definitions

> . . .
>
> C. *"Annual Report for claims-made liability insurance" shall mean a list of all claims-made liability insurance policy forms, endorsements, disclosure forms, and evidence of coverage currently in use and issued or delivered to any policyholder in Colorado, including the titles of the programs or products affected by the forms.*
>
> . . .
>
> H. *"Entity" shall mean any organization that provides … claims-made liability insurance, …*

. . .

Section 5. Rules

. . .

B. *Not later than July 1 of each year, each … claims-made liability insurer shall file an Annual Report of policy forms including a fully-executed certificate of compliance*.

. . .

D. Elements of Certification

The elements of certification as determined by the Commissioner, which must be included in the Colorado Health Coverage Certification Forms, … and the Colorado Claims-Made Liability Insurance Certification Form are as follows:

. . .

6. *A statement that the officer signing the certification form certifies:*

. . .

d. *For Listings of New Contract Forms and Annual Reports for claims-made liability insurance, the certification must include a statement that the policy forms identified on the Listing of New Policy Forms or Annual Report provide all applicable mandated coverages and that such forms are in full compliance with Colorado insurance laws and regulations*, or [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its annual reports for claims-made liability insurance dated June 22, 2007, and June 27, 2008, for the examination period of January 1, 2008, through December 31, 2008, include only five (5) of the 127 claims-made forms in use during that time. A total of 122 claims-made liability policy forms, declarations, endorsements and disclosure forms disclosed to the examiners as being in use during that time were not included in the list of forms in the annual reports.

Recommendation #6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-419, C.R.S., and Colorado Insurance Regulation 1-1-6. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its forms certification practices, submitted updated complying forms certifications for its claims-made liability and has implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

Issue E2: Failure, in some cases, to include a complete list of forms and some elements of certification in its long-term care health coverage certifications.

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

(1) *All sickness and accident insurers,* … authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, … or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. …*

(2)(a) All sickness and accident insurers … shall also submit to the commissioner a list of any new policy form, application, endorsement, or rider at least thirty-one days before using such policy form, application, endorsement, or rider for any health coverage. *Such listing shall also contain a certification by an officer of the organization that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer's good faith knowledge and belief, with Colorado law.* The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

Colorado Insurance Regulation 1-1-6, promulgated under the authority of §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states in part:

Section 3. Applicability and Scope

This regulation applies to all insurers and other entities authorized to conduct business in Colorado which provide health coverages, … who are required to fully execute and file, with each Listing of New Policy Forms or Annual Report of policy forms, a certification.[Emphasis added.]

Section 4. Definitions

. . .

D. *"Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used a part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.*

. . .

F. *"Certification of compliance" shall mean a certification form, which contains elements of certification as determined by the Commissioner, signed by a designated officer of the entity. If the individual signing the certification is other*

than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, general counsel or an actuary that is also a corporate officer, documentation should be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. This documentation is to be submitted with every filing.

. . .

H. *"Entity" shall mean any organization that provides … health coverage in this state. For the purpose of this regulation, "entity" includes … entities providing a plan of health insurance or health benefits subject to the Colorado insurance laws and regulations.*

I. *"Health Coverage Compliance Guide" shall mean a form prescribed by the Commissioner, which provides guidance for certifying the compliance of any health coverage form with Colorado insurance laws and regulations.*

. . .

M. "Listing of New Policy Forms for health coverage" shall mean a list of any new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado and the title of the program or product affected by the forms, and the effective date the form will be used

. . .

O. *"Officer of an entity" shall mean the president, vice-president, assistant vice president, corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the Board of Directors (a copy of the appointment is required with each filing).*

P. *"Program" shall mean the title of an entity's insurance program, product* or preneed funeral contract. [Emphases added.]

. . .

Section 5. Rules

A. *At least 31 days prior to using any new form … each entity, subject to the provisions of the regulation, shall file, in a format prescribed by the Commissioner, a Listing of New Policy Forms including a fully-executed certificate of compliance.*

. . .

C. *Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance. . . .*

D. Elements of Certification

The elements of certification as determined by the Commissioner, which must be included in the Colorado Health Coverage Certification Forms, . . . are as follows:

1. The name of the entity;

2. *A statement that the officer signing the certification form is knowledgeable of accident and health insurance or health care benefits . . . being certified;*

3. *A statement the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, preneed funeral contracts or other evidences of health care coverage identified in the Listing of New Policy Forms or Annual Report, . . .*

4. *A statement that the officer signing the certification form has read and understands each applicable law, regulation and bulletin;*

5. *A statement that the officer signing the certification form is aware of applicable penalties for certification of noncomplying form or contract;*

6. *A statement that the officer signing the certification form certifies:*

   a. *For Listings of New Policy Forms for health coverage … that the certifying officer has reviewed, signed and placed on file the health coverage compliance guide, … and to the best of the officer's good faith, knowledge and belief, the documents identified on the listing of new policy forms provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations;*

   b. *For Annual Reports of health coverage, that the documents identified on the listing provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations;*

   . . .

   d. *For Listings of New Contract Forms and Annual Reports for claims-made liability insurance, the certification must include a statement that the policy forms identified on the Listing of New Policy Forms or Annual Report provide all applicable mandated coverages and that such forms are in full compliance with Colorado insurance laws and regulations,* or

   . . .

7. The name and title of the officer signing the certification form and *the date the certification form is signed;* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that in some cases, the long-term care new forms certification filings did not include a complete listing of forms. In addition, the Annual Report for long-term care coverage provided as the 2008 report is not dated, as required, and is missing other required elements of an Annual Report of health coverage including a fully executed certificate of compliance by an officer of COPIC Insurance Company and the documentation of the signer's appointment by the Board of Directors and authorized to certify the forms. The document provided by the Company as its 2008 Annual Report of health coverage consists of the following heading and single-paragraph statement:

COPIC Insurance Company
Actuarial Certification for Annual Report
Policy Forms: LTC-CD9-COPIC, LTQ11-336-CP-998, LTC-GMP-COPIC

> I hereby certify that, to the best of my knowledge and judgment, for the above captioned forms, the benefits are reasonable in relation to the premiums and that the rates are not excessive, or unfairly discriminatory. The Company is in the process of assessing the adequacy of rates.

This statement is signed by Del L. Winkelman, M.A.A.A., Chief Actuary, MedAmerica Insurance Company. Although COPIC may delegate the responsibility for filing the Annual Report of health coverage forms to another entity, the filing must be certified by an officer of COPIC Insurance Company.

It appears the following forms may be in use but there is no documentation showing they have been certified in either a Listing of New Policy Forms for health coverage or in an Annual Report of forms. There is also no record of a fully executed certificate of compliance for any of these forms.

Form	Form Name	Edition Date
COPIC-LTC-03/08	COPIC CARE Long-Term Care Insurance	03/08
LTC-G-COPIC	COPIC CARE Long-Term Care Insurance Coverage Statement	8/2006

The following form was certified as a claims-made policy, but was not identified as also including long-term care insurance:

Form	Form Name	Edition Date
CO PLI	Colorado Medical Professional Liability Policy	01/08

Pages 16 and 17 have long-term care provisions and should have been so identified in the certification or separately certified.

Finally, it appears that MedAmerica is issuing schedules of coverage to COPIC policyholders on COPIC Insurance Company's behalf and there is no documentation indicating a schedule of coverage has been certified, either as a new policy form or in an Annual Report of health forms.

Form	Form Name	Edition Date
GMP_Schd.pdf	Policy Schedule	No date

(Form number is handwritten on the form)

Recommendation #7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-107.2, C.R.S**.,** and Colorado Insurance Regulation 1-1-6. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its forms certification practices, submitted updated complying forms certifications for its long-term care insurance and has implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

Issue E3: Failure, in some cases, to assign a unique identifying form number to claims-made liability insurance policy forms.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) *The following are defined* as unfair methods of competition and *unfair or deceptive acts or practices in the business of insurance:*
>
> . . .
>
> (b) *False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a* newspaper, magazine, or other *publication*, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, *or in any other way,* an advertisement, announcement, or statement containing any assertion, representation, *or statement* with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or *misleading;*
>
> . . .
>
> (t) Certifying pursuant to section 10-4-419 or issuing, soliciting or *using a claims-made policy form, endorsement or disclosure form that does not comply with statutory mandates.* Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109. [Emphases added.]

Section 10-4-419, C.R.S., Claims-made policy forms, states in part:

> (7) *All insurers providing insurance on a claims-made basis* and who are authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, disclosure form, or any other evidence of coverage issued* or delivered to any policyholder in Colorado. Such listing shall be submitted by July 15, 1993, and not later than July 1 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or disclosure form in use complies with Colorado law. *The necessary elements of the certification shall be determined by the commissioner.* [Emphases added.]

Colorado Insurance Regulation 1-1-6, Concerning the elements of certification for accident and health forms, private passenger automobile forms, commercial automobile with individually-owned private passenger automobile-type endorsement forms, claims-made liability forms, preneed funeral contracts and excess loss insurance in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act", promulgated under the authority of §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states in part:

Section 4. Definitions

. . .

C. *"Annual Report for claims-made liability insurance" shall mean a list* of all claims-made liability insurance policy forms, endorsements, disclosure forms, and evidence of coverage currently in use and issued or delivered to any policyholder in Colorado, including the titles of the programs or products affected by the forms.

. . .

H. *"Entity" shall mean any organization that provides … , claims-made liability insurance, . . .* [Emphases added.]

Section 5. Rules

D. Elements of Certification

. . .

6. A statement that the officer signing the certification form certifies:

. . .

d. *For Listings of New Contract Forms and Annual Reports for claims-made liability insurance, the certification must include a statement that the policy forms identified on the Listing of New Policy Forms or Annual Report* provide all applicable mandated coverages and that such forms are in full compliance with Colorado insurance laws and regulations, and [Emphasis added.]

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109 (1), C.R.S., states in part:

Section 4. Records Required for Market Conduct Purposes

A. *Every entity subject to the Market Conduct Process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, ….* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that the listing of contract forms and copies of the forms provided for review include eight (8) forms with form numbers and edition dates identical to those of at least one other form. In each case, the forms with the same numbers and edition dates are not identical. This is misleading. A policyholder reviewing a policy would not know whether the correct form was attached and, because the provisions of the two forma are different, could be misled regarding the coverage provided by the policy.

The forms must be listed and identified in the annual forms certification filings. Without a unique identifier, the forms are not properly listed and identified. In addition to misleading policyholders, the practice of maintaining and providing such similarly identified forms could be misleading to market

conduct examiners. Examiners might not be readily able to ascertain which of the forms are actually being used, whether the correct form was attached to the policy and which forms the Company certified for compliance with Colorado insurance laws.

Recommendation #8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 & 10-4-419, C.R.S., and Colorado Insurance Regulations 1-1-6 and 1-1-7. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its form identification and numbering practices, made appropriate revisions to affected forms and implemented necessary procedural changes in order to ensure compliance with Colorado insurance laws.

Issue E4: Failure, in some cases, to include the required provisions for cancellation and non-renewal in medical malpractice policy forms.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (a) Misrepresentations and false advertising of insurance policies: *Making,* issuing, circulating, *or causing to be made,* issued, or circulated, *any* estimate, circular, statement, sales presentation, *omission,* or comparison *which*:
>
> (I) *Misrepresents the* benefits, advantages, *conditions, or terms of any insurance policy;* or [Emphases added.]

Section 10-4-107, C.R.S., Cancellation of medical malpractice policies states, in part:

> (1) *A notice of cancellation of a medical malpractice policy shall be valid only if it is based on one or more of the following reasons:*
>
> *(a) Nonpayment of premiums; or*
>
> *(b) The license of the insured health care provider has been suspended or revoked by the appropriate state regulatory authority; or*
>
> *(c) The insured knowingly made a false statement on the application for insurance; or*
>
> *(d) There has been a substantial change in the exposure or risk other than that indicated in the application and underwritten as of the effective date of the policy unless the insured has notified the insurer of the change and the insurer accepts such change.* [Emphases added.]
>
> (2) This section shall not apply to any policy or coverage which has been in effect less than sixty days at the time the notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

Section 10-4-108, C.R.S., Notice, states in part:

> (1) *No notice of the cancellation of a policy to which section 10-4-107 applies shall be valid unless mailed or delivered by the insurer to the named insured at least ninety days prior to the effective date of cancellation; but, where cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reasons therefor shall be given.* … [Emphasis added.]

Section 10-4-109, C.R.S., Nonrenewal of medical malpractice policies, states in part:

(1) *No insurer shall refuse to renew a policy of medical malpractice insurance unless such insurer or its agent mails or delivers to the named insured, at the last address shown in the insurer's records, at least ninety days' advance notice of its intention not to renew.*

Section 10-4-109.7, Notice of intent prior to cancellation of certain policies of insurance, states in part:

(1) No insurer shall cancel a policy of insurance that provides coverages on commercial exposures such as general comprehensive liability, municipal liability, automobile liability and physical damage, fidelity and surety, fire and allied lines, inland marine, errors and omissions, *excess liability,* products liability, police liability, *professional liability,* or false arrest insurance *unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least forty-five days in advance a notice of the company's intention to cancel; but, where cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reasons therefor shall be given.*

Section 10-4-110, C.R.S., Notice of intent prior to nonrenewal of certain policies of insurance, states in part:

(1) *No insurer shall refuse to renew a policy of insurance that provides coverages on commercial exposures such as* general comprehensive liability, … *professional liability,* … unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least forty-five days in advance a notice of the company's intention not to renew.

. . .

(4) An insurer's failure to mail notice of intent shall be considered a manifestation of its willingness to renew.

It appears that the Company is not in compliance with Colorado insurance law in that the cancellation and non-renewal provisions in two of its policies indicate only that state law will be followed. The forms are unclear in that they do not include the specific requirements for cancelling or non-renewing medical malpractice policies. By this omission, the Company provides incomplete information to its policyholders and they might not know whether the Company was in compliance with the actual requirements of Colorado insurance law should it cancel or non-renew the policy. Such omission appears to misrepresent the conditions and terms of the policy.

Regarding cancellation, the Company's two forms state:

This policy can be cancelled or non-renewed by the first named insured or by COPIC only in accordance with the terms of applicable state law

Form Number	Name	Edition Date
COPIC Insurance Policy Form CO HPL	Health Care Facility Liability Policy	03/08

CO UMB Health Care Facility Umbrella Policy 03/05
(Revised 10/04)

Recommendation #9

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-4-107, 10-4-108, 10-4-109 and 10-4-119, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its policy contract forms and implemented necessary revisions in order to ensure compliance with Colorado insurance laws.

Issue E5: Failure to include in policy forms a provision indicating the insured's approval and acknowledgement, by signature is required on the written endorsement for certain exclusionary changes to the policy at renewal.

Section 10-4-419, C.R.S., Claims-made policy forms states, in part:

> (1) *No insurer shall use or issue any policy, certificate, or contract of insurance or any portion thereof which provides coverage on a claims-made basis unless* it has been certified by the insurer and the insurer has filed a certification with the commissioner that *such policy endorsement or disclosure form or any portion thereof which provides coverage on a claims-made basis conforms to Colorado law pursuant to subsection (2) of this section* and any rules and regulations promulgated pursuant to subsection (3) of this section.
>
> (2) *A claims-made policy shall not be delivered or issued for delivery to any person in this state unless:* [Emphases added.]
>
> . . .
>
> (f) The insured approves and acknowledges, by signature on the written endorsement, any exclusionary endorsement which excludes coverage in a renewal period for claims from certain known occurrences, events, products or locations.

It appears that the Company is not in compliance with Colorado insurance law in that there is no indication in the policy forms that the Company requires the insured's approval and acknowledgment by signature on the written endorsement at renewal of certain exclusionary endorsements.

The Company's policy forms include the language as indicated below.

The Colorado Professional Liability Policy and the Colorado Miscellaneous Medical Professional Liability Policy include:

> XV. GENERAL CONDITIONS
>
> . . .
>
> 15.6 Changes
>
> 15.6.1 The terms of this Policy shall not be waived, modified, or changed except by endorsement issued to form a part of this Policy signed by Our duly authorized agent.

The Colorado Health Care Facility Liability Policy includes:

> 5. RULES AND CONDITIONS
>
> . . .

5.6 Changes

5.6.1 Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or stop COPIC from asserting any right under the terms of this policy, nor shall the terms of this policy be waived or changed, except by endorsement issued by us to form a part of the policy.

The Colorado Health Care Facility Umbrella Policy includes:

XII. Conditions

. . .

14. Changes. Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or stop COPIC from asserting any right under the terms of this policy, nor shall the terms of this policy be waived or changed, except by endorsement issued by us to form a part of the policy.

Form Number	Name	Edition Date
COPIC Insurance Policy Form CO PLI	Medical Professional Liability Policy	01/08
COPIC Insurance Policy Form CO MML	Miscellaneous Medical Professional Liability Policy	01/08
COPIC Insurance Policy Form CO HPL	Health Care Facility Liability Policy	03/08
CO UMB	Health Care Facility Umbrella Policy	03/05 (Revised 10/04)

Recommendation #10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-419, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its policy contracts and implemented necessary forms revisions in order to ensure compliance with Colorado insurance laws.

Issue E6: Failure to clearly and adequately disclose the policy provisions by including incorrect and/or incomplete definitions or statements.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (a) Misrepresentations and false advertising of insurance policies: *Making, issuing, circulating, or causing to be made, issued, or circulated, any* estimate, circular, statement, sales presentation, *omission*, or comparison which:
>
> (I) *Misrepresents the* benefits, advantages, *conditions, or terms of any insurance policy;* or [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that, in some cases, there is no specific definition in the policy forms that clearly indicates what is included when referring to its "policy". The Company's definition of "Declaration Page" is unusual. While a Company may define certain words in its policies to fit its own specific coverage and/or conditions, it must ensure that the definitions and use of such words are not incomplete and thereby misleading to policyholders.

The Company's definition of Declaration Page would seem to lead a policyholder to expect the Declarations to then include a list of the endorsements included in the policy, which is a common practice. However, the Company's two policy forms titled "Declarations" do not include a list of forms and endorsements or other forms applicable to the policy. There is also no separate forms index listing the forms and endorsements attached to these policies. Without such a list and no definition of "policy" the provision below is incomplete and potentially misleading to policyholders.

There is not a complete or accurate definition of the entire contract. To indicate the entire contract is composed of the policy and the statements in the application without clearly defining what is included in the term "Policy" as used within the policy form is an incorrect statement which is potentially misleading. From this definition, there is no way to determine whether the Declarations, and the endorsements the Company has defined as included in the Declarations, are included in the contract. In addition, unless there is a definition of "Policy" including the application, the application and the statements in it are not a part of the entire contract. This is true even when the Company relies upon the statements in the application to issue the policy.

The Colorado Professional Liability Policy and the Colorado Miscellaneous Medical Professional Liability Policy include the following provisions:

> Important Notice to Our Policyholders
>
> Only the provisions of this Policy and any attached Declaration Pages as amended from time to time determine Your rights, duties, scope of insurance protection and what is and what is not covered by this Policy.
>
> VII. Definitions

7.3 "Declarations Page" refer to any and all declarations and/or endorsements attached to this Policy.

. . .

XV. General Conditions

15. 11 Entire Contract

15.11.1 By acceptance of this Policy, You agree that the statements in the original, supplemental or renewal application are Your representations to Us and that this Policy is issued by Us in reliance upon such representations and that this Policy embodies all agreements existing between You and Us and relating to the coverage under this Policy.

Form Number	Name	Edition Date
COPIC Insurance Policy Form CO PLI	Medical Professional Liability Policy	01/08
COPIC Insurance Policy Form CO MML	Miscellaneous Medical Professional Liability Policy	01/08

Recommendation #11
Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms to include complete definitions and information in compliance with Colorado insurance law.

Issue E7: Failure to include a statement in long-term care certificates of insurance that the group master policy determines contractual provisions, as required by Colorado insurance law.

Section 10-19-112, C.R.S., Outline of coverage - certificate, states in part:

> (3) *A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include*:
>
> . . .
>
> (c) *A statement that the group master policy determines governing contractual provisions; and* [Emphases added.]

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 8. Required Disclosure Provisions
>
> M. *A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state shall include:*
>
> . . .
>
> 3. *A statement that the group master policy determines contractual provisions.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that the long-term care certificates of insurance do not include a statement that the group master policy governs the contractual provisions.

Form Number	Name	Edition Date
LTC-G-COPIC	Copic Care Your Long-Term Care Coverage Details	08/2006
LTC-G2-Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-19-112, C.R.S., and Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its long-term care certificate forms, submitted updated complying forms certifications for its long-term care insurance and has distributed the revised certificates to insured persons in order to ensure compliance with Colorado insurance law.

Issue E8: Failure, in some cases, to provide a disclosure statement form with the required content and format and to execute and maintain the required proof of delivery and acceptance of the disclosure form.

Section 10-4-419, C.R.S., Claims-made policy forms states, in part:

(2) *A claims-made policy shall not be delivered or issued for delivery to any person in this state unless:*

(a) The insurer defines the nature of the risks or exposures to be insured on the claims-made policy;

(b)(I) *The policy contains clear and adequate disclosure* and alerts the insured to the fact that the policy is a claims-made policy and explains the unique features distinguishing it from an occurrence policy and relating to renewal, extended reporting periods, and coverage of occurrences with long periods of exposure. *The commissioner shall promulgate regulations which establish proof of delivery and acceptance thereof by the policyholder and set forth the contents and format of the minimum disclosures required under this article.*

(II) Such disclosures shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the exceptions, reductions, and limitations contained in the policy;

(C) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums;

(D) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) *The policy clearly defines the events and conditions which trigger coverage and defines when and how a claim is deemed to be made or is deemed made;*

(d) The policy offers, at the insured's option, the purchase of an extended reporting period of at least one year for claims not filed during the policy period. The premium may not exceed two hundred percent of the expiring policy premium unless the adjusted premium is determined by the commissioner to be inadequate based upon section 10-4-403 and based upon an opinion of a qualified actuary submitted on behalf of the insurer.

…

(7) *All insurers providing insurance on a claims-made basis* and who are authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any* policy form, endorsement, *disclosure form*, or any other evidence of coverage issued or delivered to any policyholder in Colorado. Such listing shall be submitted by July 15, 1993, and not later than July 1 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or disclosure form in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissione*r*. [Emphases added.]

Colorado Insurance Regulation 5-1-8, promulgated under the authority of § 10-1-109, C.R.S., states in part:

Section 2. Basis and Purpose

The purpose of this regulation is to establish standards for the training of all persons engaged in the sale or consultation of claims-made policies in compliance with §10-4-419(2)(g) or in adjusting claims under such policies, and to provide minimum disclosure standards for claims-made insurance policies or in adjusting claims under such policies.

Section 3. Rules

B. Disclosure Form

At the time of commencement of coverage either the insurer or the insurance producer shall execute a proof of delivery and acceptance of the disclosure form. The proof of delivery and acceptance shall be maintained in the insurer or producer file for at least two years beyond the term of the policy.

In connection with the sale of any claims-made policy, the insurer shall give to the insured a disclosure statement substantially in the following form:

DISCLOSURE FORM
CLAIMS-MADE POLICY

IMPORTANT NOTICE TO POLICYHOLDER

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your

insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer.

There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have.

If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for _____ (insert brief description of coverage) up to the maximum dollar limit specified in the policy.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure.

If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.

2. When replacing a claims-made policy with a claims-made policy, you should consider the following:

a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or

b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.

3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.

It appears that the Company is not in compliance with Colorado insurance law in that, in some cases, a disclosure statement form with the content and format outlined in Colorado Insurance Regulation 5-1-8 does not appear to be included with some policy forms. In addition, some of the disclosures that are required in the policies are not included, and the one policy that does appear to have a disclosure form includes that disclosure within its policy form instead of as a separate form. Finally, no proof of delivery and acceptance form was provided to enable the examiners to confirm one was available for use by either the Company or its producers.

No disclosure form was provided for the first three policies listed below. These three policies also do not include a disclosure regarding premium change at renewal, which is required if the Company reserves that right.

The fourth policy form listed below includes a disclosure form, which is not a stand alone form but is included on pages ii and iii of the policy form. The text is substantially the same as the required form and content of the regulation. Because the disclosure is part of the policy, it is not clear how the executing of proof of delivery and acceptance, if completed, would specifically address the delivery and acceptance of the disclosure form. A proof of delivery form, if one exists and is completed for this policy when delivered, would seem to address the policy delivery and not specifically the disclosure form delivery and acceptance as required by Colorado insurance law.

Form Number	Name	Edition Date
COPIC Insurance Policy Form CO PLI	Medical Professional Liability Policy	01/08
COPIC Insurance Policy Form CO MML	Miscellaneous Medical Professional Liability Policy	01/08
CO UMB	Health Care Facility Umbrella Policy (Revised 10/04)	03/05
COPIC Insurance Policy Form CO HPL	Health Care Facility Liability Policy	03/08

Recommendation #13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-419, C.R.S. and Colorado Insurance Regulation 5-1-8. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has amended its forms, implemented a proof of delivery and acceptance form and procedure in order to ensure compliance with Colorado insurance laws.

Issue E9: Failure to include in long-term care coverage policy form and certificates a provision stating a policyholder must request in writing or sign any amendment which reduces or eliminates coverage.

Section 10-16-214, C.R.S., Group sickness and accident insurance states, in part:

> (3)(a) Except as provided for in subsection (2) of this section, *all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:*
>
> (IV) A provision that no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer; *but any such amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder;* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its long-term care group policy and certificates of insurance do not include provisions indicating a policyholder must either request in writing or sign any amendment to the policy which reduces or eliminates coverage.

The Company's long-term care policy form provides:

> Entire Contract, Changes
>
> . . .
>
> Any change in the Policy must be approved by one of the Company's officers and mutually agreed to by the PolicyHolder. Any change must also be endorsed on or attached to this Policy. No insurance agent has the authority to change this Policy or to waive any of its provisions.

The Company's certificates of insurance provide:

> . . . Any change must be approved by one of Our officers and mutually agreed to by You. It must be endorsed on or attached to the Policy. No insurance agent has the authority to change this Certificate or to waive any of its provisions.

Form Number	Name	Edition Date
LTC-GMP-COPIC	Copic Care Long-Term Care Insurance	None Provided
LTC-G-COPIC	Copic Care Your Long-Term Care Coverage Details	08/2006

LTC-G2_Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-214, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms, submitted updated complying forms certifications for its long-term care insurance in order to ensure compliance with Colorado insurance law.

Issue E10: Failure, in some cases, to include definitions which satisfy the requirements of Colorado insurance law.

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 3. Applicability
>
> *The requirements of this regulation shall apply to long-term care policies delivered or issued for delivery in this state, on or after the effective date hereof.* This regulation also applies to any acceleration of benefits provided by a life or annuity policy, unless otherwise specifically exempted by this regulation.
>
> Section 5. Activities of Daily Living
>
> *No long-term cared insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following:*
>
> A. "Activities of daily living" means at least *bathing*, continence, dressing, eating, toileting and transferring.
>
> . . .
>
> D. Bathing means washing oneself by sponge bath or in either a tub or shower, including the *task of getting into or out of the tub or shower.*
>
> . . .
>
> I. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table*) or by a feeding tube or intravenously.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that, in some cases, required definitions for long-term care coverage certificates of insurance are missing. The Company's long-term care coverage certificate LTC-G3-COPIC does not include the required definitions of eating and bathing required under Colorado insurance law.

Form Number	Name	Edition Date
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided

Recommendation #15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms, submitted updated complying forms' certifications for its long-term care insurance and distributed the revised forms to policyholders in order to ensure compliance with Colorado insurance law.

Issue E11: Failure to include a correct provision for continuation of coverage in a long-term care certificate when the eligibility for coverage is based upon a relationship that terminates.

Section 10-19-106, C.R.S., Rules on disclosure states:

> *The commissioner may adopt rules and regulations that include standards fo*r full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, *continuation* or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. Such rules and regulations shall be in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S. [Emphases added.]

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 6. Policy Practices and Provisions
>
> …
>
> D. Continuation or Conversion
>
> 1. *Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.*
>
> 2. *For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.* Group policies that restrict provision of benefits and services from, or contain incentives to use, certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
>
> 3. *For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured*

under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. *For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made*. Where the group policy from which conversion is made restricts provision of benefits and services from, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

5. *Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy.* The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

…

10. *Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that, in one case, the provisions of its long-term care certificate does not include a correct statement regarding coverage for an individual whose eligibility is based upon his or her relationship with another person if the reason for the loss of eligibility is due to the termination of the relationship due to dissolution of the marriage. While the spousal benefit-sharing option attached to and forming a part of the group master policy includes the correct provisions, the statement in this certificate is directly contrary to that, stating the individual in that situation is entitled only to conversion to an individual policy.

In addition, the provision requires premium payment for the converted policy within thirty (30) days after coverage under the Policy ends, instead of the correct time period of thirty-one (31) days.

The eligibility for continuation or conversion, in this case, states:

"Notwithstanding any other provision of this Section of your Statement, if You are eligible for LTC coverage based upon Your relationship to another person, You are

entitled to continue LTC coverage under the Policy as a direct payment subscriber upon termination of that relationship because of death.
If you are eligible tor LTC coverage based upon Your relationship to another person and that relationship terminates because of divorce, You are entitled to purchase an individual policy with benefits equal to Your benefits under this Statement. Premiums for the new policy will be based on Your age at the time Your LTC coverage under the Policy began. You may convert to the new policy without evidence of insurability. You must pay the premium due within 30 days after Your LTC coverage under the Policy ends."

The required statement that the group master policy governs the contractual provisions is missing from this certificate, as identified in issue E6. In addition, there is a statement in this certificate that is directly contrary to that requirement:

"Entire Contract, Changes

This statement, any Riders and attached papers, establishes a legal agreement between You and Us. . . . "

A certificate of insurance issued from a group master policy provides no contractual provisions and contains no legal agreement between parties. It merely indicates what is provided by the group master policy to which it pertains.

Form Number	Name	Edition Date
LTC-G-COPIC	Copic Care Your Long-Term Care Coverage Details	08/2006

Recommendation #16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-19-106, C.R.S., and Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its form, submitted updated complying forms certifications for its long-term care insurance and has distributed revised copies of the certificate to insured persons in order to ensure compliance with Colorado insurance law.

Issue E12: Failure, in some cases, to include all elements of an incontestability provision in a long-term care policy or certificate when including the provision.

Section 10-19-113.3, C.R.S., Incontestability period, states in part:

> (1) With respect to a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny a long-term care insurance claim under such a policy upon a showing of misrepresentation that is material to the acceptance for coverage.
>
> (2) With respect to a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and pertains to the condition for which benefits are sought. A policy or certificate that has been in force for two years shall not be contested solely on the grounds of misrepresentation. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.
>
> . . .
>
> (4) *If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payment may not be recovered by the insurer in the event that the policy or certificate is rescinded.*

It appears that the Company is not in compliance with Colorado insurance law in that, in those cases in which its long-term care policy and certificates include an incontestability provision, the provision is missing one of the required elements of incontestability. The provision does not include the element which states that the benefit payment may not be recovered by the insurer in the event that the policy or certificate is rescinded. When provided, the provision must include all the elements of the law. Following is the wording of the incontestable provision when included:

> INCONTESTABLE PERIOD
>
> During the first six (6) months an Insured Person's coverage under this Policy is in force, the Company may rescind an Insured Person's coverage under this Policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by the Insured Person that was material to the acceptance for coverage.
>
> After six(6) months but before two (2) years of policy coverage, the Company may rescind an Insured Person's coverage under this Policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that was both material to the acceptance and which pertained to the condition for which benefits are sought.
>
> After an Insured Person's coverage under this Policy has been in force for two (2) years, the Company may rescind an Insured Person's coverage under this Policy or deny an otherwise valid

long-term care insurance claim only upon a showing that the Insured Person knowingly and intentionally misrepresented relevant facts relating to the Insured Person's health.

Form Number	Name	Edition Date
LTC-GMP-COPIC	Copic Care Long-Term Care Insurance	None Provided
LTC-G2_Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-19-113.3, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms, submitted updated complying forms certifications for its long-term care insurance in order to ensure compliance with Colorado insurance law.

Issue E13: Failure, in some cases, to include the required (thirty) 30-day free look provision, or including it other than on the first page as required under Colorado insurance law.

Section 10-19-111, C.R.S., Right to return policy – free look, states in part:

> A long-term care insurance applicant has the right to return the policy or certificate within thirty days after its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issue pursuant to a policy issued to a group defined in section 10-19-103(4)(a), the applicant is not satisfied for any reason. *A long-term care insurance policy or certificate shall contain a notice, prominently printed on the first page or attached thereto, stating in substance that the applicant has the right to return the policy or a certificate within thirty days after its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section 10-19-103(4)(a), the applicant is not satisfied for any reason. This section shall also apply to the denial of application. Any refund shall be made within thirty-days after the return or denial.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that, in some cases, its long-term care policy and certificate does not include a thirty (30) day free-look notice, the notice is not on the first page, or the premium refund provision does not include the time frame required by Colorado insurance law.

The provision when included states:

> If the Certificate of Insurance does not meet the Insured Person's needs, he or she may return it to the Company or agent within 30 days. If the Certificate is returned, coverage under this Policy will be deemed void from the Insured Person's effective date as shown in the Certificate Schedule. Any premium paid will be refunded.

Form Number	Name	Edition Date
LTC-GMP-COPIC	Copic Care Long-Term Care Insurance	No Date
LTC-G-COPIC	Copic Care Your Long-Term Care Coverage Details	08/2006
LTC-G2-Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-19-111, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms and submitted updated complying forms certifications for its long-term care insurance in order to ensure compliance with Colorado insurance law.

Issue E14: Failure to provide the required Outline of Coverage in the format and with content required by Colorado insurance law.

Section 10-19-112, C.R.S., Outline of coverage – certificate, states in part:

(1)(a) *An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.*

(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

. . .

(e) *In the case of a policy issued to a group defined in section 10-19-103 (4) (a), an outline of coverage shall not be required to be delivered if the information described in subsection (2) of this section is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.* [Emphases added.]

(2) *The outline of coverage shall include all of the following*:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) *A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains the governing contractual provisions;*

(e) *A description of the terms under which the policy or certificate may be returned and premium refunded*;

(f) *A brief description of the relationship of cost of care and benefits*;

(g) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. sec. 7702B (b) of the federal "Internal Revenue Code of 1986", as amended.

(3) *A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:*

. . .

(c) *A statement that the group master policy determines governing contractual provisions; and*

. . .

(6) *If an application for a* long-term care insurance contract or *certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval*. [Emphases added.]

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

Section 24. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of §10-19-112, C.R.S. in prescribing a standard format and the content of an Outline of Coverage.

A. The Outline of Coverage shall be a freestanding document, using no smaller than ten-point type.

B. *The Outline of Coverage shall contain no material of an advertising nature*.

C. Text that is capitalized or underscored in the standard format Outline of Coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

D. *Use of the text and sequence of text of the standard format Outline of Coverage is mandatory, unless otherwise specifically indicated*.

E. *The Outline of Coverage shall be formatted as demonstrated in Appendix J.* [Emphases added.

It appears that the Company is not in compliance with Colorado insurance law in that no outline of coverage is provided to prospective enrollees. Neither the group policy nor the certificates include all the elements of an outline of coverage required by Colorado insurance law.

Recommendation #19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-19-112, C.R.S. and Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has developed an appropriate outline of coverage, submitted updated forms certification filings for its long-term care insurance and has implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

Issue E15: Failure, in some cases, to include the required reinstatement provisions in long-term care group policy coverage and certificates of insurance, and to provide and retain the required forms for notice and waiver of the right to designate another person to receive notice of lapse or termination of long-term care certificate of insurance.

Colorado Insurance Regulation 4-4-1, Concerning Requirements for Long-Term Care Insurance promulgated under the authority of §§ 10-1-109, 10-7-113(3), 10-16-107(1), 10-19-106, 10-19-113.7, and 10-3-1110(1), C.R.S., states in part:

> Section 7. Unintentional Lapse
>
> Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:
>
> A.
>
> 1. Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." *The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.*[Emphasis added.]
>
> B. Reinstatement. In addition to the requirement in Subsection A of this section, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination *and shall allow for the collection of past due premium, where appropriate*. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that, in some cases, its long-term care group policy and certificates of insurance do not include reinstatement provisions with regard to unintentional lapse due to functional incapacity or cognitive impairment. It appears that, in some cases, neither a form giving notice of the right to designate one other person to receive notice of cancellation, nor a form waiving the right to such designation, is sent to insured persons periodically as required. If a notice or a waiver form is sent and either is returned, neither is retained in the record of the policy as provided for review.

The reinstatement provisions, when included, do not include all provisions required under Colorado insurance law, or include provisions contrary to Colorado insurance law. The provisions, in some cases, do not include the circumstances under which reinstatement is required, or the time frame after lapse within which reinstatement must be requested. They also do not include notification that premium must be paid retroactive to the date of termination or the limitations on the standards for proof of cognitive impairment or loss of functional capacity that may be applied in determining eligibility for reinstatement. In one case, the provision states:

> "The Company will do a benefit eligibility assessment before deciding on reinstatement. … No benefits will be paid for care received prior to the date the benefit assessment is performed."

It appears this Company benefit assessment follows receipt of proof of functional incapacity or cognitive impairment. This provision appears even though payment of premium retroactive to the termination date is required by law, and despite the inclusion in other forms of the statement that the insured person may request "reinstatement with no break in coverage".

One provision (when included) states:

> If the Insured Person's coverage under the Policy terminates for non-payment of premium within the Grace Period, the Insured Person may request reinstatement with no break in coverage. If the Company honors this request, or if the Company fails to respond to it within 45 days, the Insured Person's coverage under this Policy will be reinstated retroactive to the date the Insured Person's coverage under this Policy terminated. Once reinstated, the Insured Person must pay the premium due retroactive to the date the Insured Person's coverage under this Policy terminated.

Colorado insurance law requires the notice of the right to designate one other person to receive a cancellation notice and the form for waiver of such right to include specific prescribed language. The 2008 certification of forms provided by the Company included neither a notice form nor waiver form. In addition, it appears neither a notice nor a waiver form is sent to the insured person as required, no less often than once every two years for existing individual policies.

The Company explained it no longer issues individual long-term care policies. Individual policies previously issued continue in force until they are cancelled by request of the policyholder or lapse due to nonpayment of premium. The Company stated the policies are guaranteed renewable, nothing is sent to the insured persons at renewal and there is no renewal file to review. No documentation of notices or waiver forms sent to insured persons was provided.

Form Number	Name	Edition Date
LTC-GMP-COPIC	Copic Care Long-Term Care Insurance	None Provided

LTC-G-COPIC	Copic Care Your Long-Term Care Coverage Details	08/2006
LTC-G2-Copic-Professional Liability Insureds	Copic Care Long-Term Care Insurance Certificate	7/27/1998
LTC-G3-COPIC (*Employees & COC)*	Copic Care Group Long-Term Care Insurance Certificate	None Provided
LTC-G4-Copic Employees	Copic Care Group Long-Term Care Insurance Certificate	8/20/1998

Recommendation #20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-4-1. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its forms, submitted updated complying form certifications for its long-term care insurance and distributed the revised forms to policyholders in order to ensure compliance with Colorado insurance law.

RATING

Issue F1: Failure to clearly disclose requirements for premium discount and continuing eligibility and provide ninety (90) day notification upon loss of discount.

Section 10-4-109.5, C.R.S., Notice of intent prior to unilateral increase in premium or decrease in coverage previously provided in medical malpractice policies, states in part:

> (1) No insurer shall increase the premium unilaterally or decrease the coverage benefits previously provided as contained in a medical malpractice policy unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least ninety days' advance notice, accompanied by the reason therefor, of the company's intention to increase the premium unilaterally or decrease the coverage benefits provided on renewal.

It appears that the Company is not in compliance with Colorado Insurance law in that its underwriting manual provides that insured physicians receiving a ten (10) percent premium discount for membership in the Colorado Medical Society (CMS) shall lose the discount when membership is dropped without providing notice.

The Underwriting manual (see attached PDF document) states in part:

> "When we are notified by CMS that a physician is no longer a CMS member, we remove the physician from the safety group rate as of the date his membership was dropped. *We do not need to provide the physician with any notice prior to doing so.*" [Emphasis added.]

This practice constitutes a unilateral premium increase without the required ninety (90) day prior notice from the insurer for the rate increase and reason thereof, which appears to be a violation of §10-4-109.5, C.R.S.

Recommendation #21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-109.5, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised its policy forms to clearly disclose the effects of CMS membership on premium rates and its procedures to ensure that notification of any premium increase is provided in a timely manner consistent with Colorado insurance law.

Issue F2: Failure, in some cases, to include specific rates, discounts, surcharges, and loads in rate filings as required by Colorado insurance law, or to include actuarial or statistical justification for such rates, discounts, surcharges and loads.

Section 10-4-401, C.R.S., Purpose-applicability, states in part:

(3) The kinds of insurance subject to this part 4 shall be divided into two classes, as follows:

(b) Type II kinds of insurance, regulated by open competition between insurers, including fire, casualty, inland marine, title, medical malpractice by a joint underwriting association regulated under part 9 of this article, credit, workers' compensation and employer's liability incidental thereto and written in connection therewith for rates filed by insurers, and all other kinds of insurance that are subject to this part 4 and not specified in paragraph (a) of this subsection (3), including the expense and profit components of workers' compensation insurance, which shall be subject to all the provisions of this part 4 except for sections 10-4-405 and 10-4-406. *Type II insurers shall file rating data, as provided in section 10-4-403, with the commissioner;* except that credit life and credit accident and health insurers shall file schedules of premium rates pursuant to sections 10-10-109 and 10-10-110. A rate filing summary for a type II kind of insurance subject to this part 4, except for workers' compensation insurance, shall be posted on the division's internet site in order to provide notice to the public. The public notice shall include the rate standards that apply pursuant to section 10-4-403 (1). Nothing in this section shall be construed to limit the right of the public to inspect a rate filing and any supporting information pursuant to part 2 of article 72 of title 24, C.R.S., or to impair the commissioner's ability to review rates and determine that the rates are not excessive, inadequate, or unfairly discriminatory. [Emphasis added.]

(4) Except for type I kinds of insurance as defined in paragraph (a) of subsection (3) of this section, prior approval of rates, schedules of rates, rating plans, rating classifications and territories, rating rules, and rate manuals with the commissioner, or his prior approval thereof, shall not be required. In lieu thereof, the provisions of paragraph (b) of subsection (3) of this section and sections 10-4-413, 10-4-414, and 10-4-418 regarding the availability of such items, the review thereof, and hearings and judicial review thereof are applicable.

Colorado Insurance Regulation 5-1-10, Rate and Rule Filing Submission Requirements Property and Casualty Insurance**,** promulgated under the authority of §§ 10-1-109~~,~~ 10-3-1110, 10-4-404, and 10-4-404.5, C.R.S., states in part**:**

Section 5 Rules

A. Rate Filings General Requirements

1. Required Submissions: All companies must submit rate filings whenever the rates charged to the new or renewal policyholders change. Included in this

requirement are changes due to periodic recalculation of experience or projections, or a change in rate calculation methodology.

2. Timing and Submission: Unless a filing is specifically identified as requiring prior approval, by statute, all filings are classified as file and use. All companies are to file a transmittal sheet, appropriate Colorado Rate and Rule Submission Form(s) (Form A is required for all filings and loss cost filings require a form B, C and/or D, as appropriate) with the rates prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate. *Additionally, all personal lines, medical malpractice and workers compensation insurance require the rating data to be submitted with the filing. The Division of Insurance may also request rating data for other lines of business along with appropriate supporting data.* All filings must be submitted to the rates and forms section of the Division of Insurance. In the case of rates requiring prior approval, if a rate increase has been implemented without Division of Insurance approval, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits. [Emphasis added]

B. Additional Rate Filing Requirements by Line

The following subsections set forth the requirements by separate lines of business that must be complied with in addition to the above general requirements.

1. Type I Lines: Type I filings are defined in Section 10-4-401, C.R.S. All filings for Type I lines of business require prior approval**.**

2. Rate Modification Plans: Rate modification plans are rating plans or procedures which provide a listing of various risk characteristics or conditions and a range of modification factors which may be applied for these characteristics or conditions to the manual rate of a particular insurance risk. Rate modification plans are regulated by Colorado Regulation 5-1-11. All requirements of Regulation 5-1-11 should be observed, in addition to the requirements of this regulation, whenever a rate modification plan is filed.

The rate filings provided by the Company to the Division have been reviewed by the Division. This review included prior rate filings from as far back as 1994, up to and including the Company's most recent 2008 filing pertaining to the Company's "Physicians and Surgeons Coverage"; "Hospital Coverage"; and "Umbrella Coverage for Hospitals" lines of business.

It appears that the Company is not in compliance with Colorado insurance law in that several rates, discounts, surcharges and/or loads used in connection with the Company's insurance plans in use during the examination period have either not been included in a prior rate filing, or were not statistically or actuarially justified and therefore may not be in compliance with Colorado insurance laws.

1. The following factors have not been filed or statistically or actuarially justified in a rate filing:

- * Residency discounts
- Rocky Mountain HMO experience credit/self-insured retention
- Cytotechnologist rating factors

2. Although these factors were listed in a filing, actuarial or statistical information justifying their use was not filed prior to use for the following discounts:

   Factors listed in the physicians and surgeons filing #222400, effective 1/1/2008

   - CMS Discount
   - * New Physician Discounts
   - Suspension of Coverage Discount
   - Part Time Discounts
   - * Experience Rating System (ERS) Discounts/Surcharges
   - * Associated Group Risk Management Program
   - * Individual Deductible Discount
   - * Loss Experience Factors
   - * Small Solo Group Discount
   - * Administrative Discounts

   Factors listed in the healthcare facilities filing #200275, effective 1/1/2006:

   - 15% load for general liability
   - 5% load for additional insureds
   - The separate charges for non-physicians (e.g., a $4000 charge for CRNAs, a $6000 charge for midwives, etc.)
   - The small hospital credit of 10%

3. The starred discounts (*) in the above lists appear to vary depending on one or more factor(s) that are not clearly explained or statistically/actuarially justified in a rate filing. The Company did not adequately explain, or statistically or actuarially justify in a rate filing, the manner in which these discounts vary in a rate filing.

All of the above discounts/surcharges/rate factors lack adequate supporting data in rate filings to justify their appropriateness and/or use, or show that they are not duplicative of other discounts/charges.

Recommendation #22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-4-401, C.R.S. and Colorado Insurance Regulation 5-1-10. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has submitted all rates, discounts, surcharges and loads in a rate filing, and that all factors filed include appropriate statistical, actuarial justification and/or other adequate supporting data (such as competitive analysis, or use solely by sophisticated policyholders) in order to ensure compliance with Colorado insurance law. Should the Company be unable to provide adequate justification for its rates, discounts, surcharges and loads, it should discontinue the use of such factors.

CLAIMS

Issue J1: Failure, in some cases, to report medical malpractice settlements or judgments to the Colorado Board of Medical Examiners within fourteen (14) days from the settlement date as required by Colorado insurance laws.

Section 10-1-120, C.R.S., reporting of medical malpractice claims, states:

> (1) Each insurance company licensed to do business in this state and engaged in the writing of medical malpractice insurance for licensed practitioners shall send to the Colorado state board of medical examiners, in the form prescribed by the commissioner of insurance, information relating to each medical malpractice claim against a licensed practitioner that is settled or in which judgment is rendered against the insured.
>
> (2) The insurance company shall provide such information as is deemed necessary by the Colorado state board of medical examiners to conduct a further investigation and hearing.

Section 13-64-303, C.R.S., Judgments and settlements – reported, states:

> Any final judgment, settlement, or arbitration award against any health care professional or health care institution for medical malpractice shall be reported *within fourteen days* by such professional's or institution's medical malpractice insurance carrier in accordance with section 10-1-120, 10-1-121, 10-1-124, or 10-1-125, C.R.S., or by such professional or institution if there is no commercial medical malpractice insurance coverage to the licensing agency of the health care professional or health care institution for review, investigation, and, where appropriate, disciplinary or other action. Any health care professional, health care institution, or insurance carrier that knowingly fails to report as required by this section shall be subject to a civil penalty of not more than two thousand five hundred dollars. Such penalty shall be determined and collected by the district court in the city and county of Denver. All penalties collected pursuant to this section shall be transmitted to the state treasurer, who shall credit the same to the general fund. [Emphasis added]

A review was performed on a random sample of seventy-six (76) medical malpractice claims from a population of one hundred (100). It appears that the Company is not in compliance with Colorado insurance law in that for forty-three (43) of the claims reviewed, the Company did not submit the "PROFESSIONAL LIABILITY INSURANCE INSURERS REPORT OF MEDICAL PRACTICE SETTLEMENT OR JUDGEMENT" form within fourteen (14) days from the settlement date as required under Colorado insurance laws.

The following shows the incidence of error for reporting medical malpractice settlements or judgments to the Colorado Board of Medical examiners as of the date of examination:

Paid Medical Malpractice Claims
January 1, 2008-December 31, 2008

Population	Sample	Incidence of Error	Percentage to Sample
100	76	43	57%

From the seventy-six (76) claim files reviewed, forty-three (43) or fifty-seven percent (57%) of the claim settlements were not reported to the Colorado Board of Medical Examiners within the fourteen (14) day time period as required under Colorado insurance law.

Recommendation #23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-1-120 and 13-64-303, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence that it has corrected its procedures to ensure that reporting of claim settlements to the Colorado Board of Medical Examiners are completed within fourteen (14) days as required by Colorado insurance law.

Summary of Recommendations

COPIC INSURANCE COMPANY

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